CONSENT TO RELEASE INFORMATION

I, _____, GIVE THE PHYSICIANS AND OFFICE STAFF OF COLUMBUS ONCOLOGY & HEMATOLOGY ASSOCIATES, INC. PERMISSION TO DISCUSS MY MEDICAL CONDITION TO THE FOLLOWING FAMILY AND FRIENDS. I ALSO GIVE PERMISSION TO DISCLOSE NECESSARY MEDICAL INFORMATION REQUIRED BY EMPLOYERS OF FAMILY MEMBERS LISTED BELOW AS NECESSARY TO COMPLETE FAMILY MEDICAL LEAVE AND RELATED APPLICATIONS.

WITH:_____

WHO IS _____ AT PH#_____
(RELATIONSHIP)

AND/OR_____

WHO IS _____ AT PH#_____
(RELATIONSHIP)

AND/OR_____

WHO IS _____ AT PH#_____
(RELATIONSHIP)

AND/OR_____

WHO IS _____ AT PH#_____
(RELATIONSHIP)

CAN WE LEAVE MESSAGES ON YOUR HOME ANSWERING MACHINE?
YES / NO PLEASE CIRCLE ONE

THIS IS AN INDEFINITE CONSENT FORM UNLESS OTHERWISE SPECIFIED.

_____ _____
PATIENT SIGNATURE DATE